



State of Rhode Island and Providence Plantations
Department of Human Services/Office of Rehabilitation Services
40 Fountain Street ~ Providence, RI 02903 ~ 401.421.7005 (V)
401.421.7016 (TDD) ~ 401.272.8090 (Spanish) ~ 401.222-3574 (Fax)
www.ors.ri.gov

ORS Use
Region:
Area:
ORS-4 Rev. 11/03

"Assisting eligible individuals with disabilities to choose, prepare for, obtain and maintain employment."

Application & Initial Information for the Vocational Rehabilitation (VR) Program

Please fill out this application to the best of your ability. If you do not feel comfortable disclosing some of the information, you can complete the application when you meet with an ORS Counselor.

Name: _____
(Last) (First) (Middle Initial)

Address: _____ Phone: _____

City/Town: _____ Zip: _____ Alternate Phone: _____ (Cell/Other)

Date of Birth: _____ Sex: ____ Veteran: Y ____ N ____ E-mail Address: _____

Social Security #: _____

Have You Previously Applied for VR Services: Y ____ N ____ Previous Name: _____

Do you receive SSI and/or SSDI and intend to work? SSI ____ SSDI ____ (Attach award letter, if available.)

What is your disability? _____ Unknown: _____

Are you blind or visually impaired? Y ____ N ____

What is your employment or career goal(s)? _____

How did you learn about VR? _____

Who referred you? _____

**I am applying for Vocational Rehabilitation Services because I want to work,
or maintain employment if I am employed.**

Signature: _____ Date: _____

Parent or Guardian (if applicable) _____ Date: _____

Do you want to register to vote? Y ____ N ____ Have you ever been convicted of a felony? Y ____ N ____

Your assistance in providing the information requested on the following pages will help speed up your eligibility and employment plan process. A Vocational Rehabilitation Representative can assist you in completing the information if you wish. Please contact (401) 421-7005 (Intake) or (401) 421-7016 (TTY), if you need assistance to complete the form. En Espanol, (401) 272-8090.

(Over)

WORK & EDUCATIONAL EXPERIENCE

Work History (Most recent first or attach resume)

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason for Leaving Job: _____

* * *

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

* * *

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

* * *

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

Education & Training

Highest Grade Completed: _____ Special Education [IEP]: Y __ N __ 504: Y __ N __ GED: Y __ N __
Did you receive support services in school? Y __ N __ Describe (e.g. technology, aide, etc.): _____

High School: _____ College: _____
Degree Obtained: _____ Year: _____
Other Training: _____
Skills/Hobbies (e.g. languages, computer, skills, licenses, volunteer experience, etc.): _____

INFORMATION ABOUT YOUR DISABILITY

DISABILITY/MEDICAL CONDITION (What prevents you from working?)

Describe your limitations to employment: _____

Medical condition (if known): _____

PHYSICIANS/HOSPITAL/CLINIC

Dates of Service

Name(s) and Address: _____

MEDICATIONS/TREATMENTS

Name/Type

Dosage/Frequency

MEDICAL COVERAGE

Insurance/Benefit

Claim No.

Provided by Employer

EQUIPMENT NEEDED TO WORK

COUNSELOR’S COMMENTS:

DEMOGRAPHICS

Number of Persons in Household: _____ Number of Dependents: _____

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Check All That Apply: White ___ Black ___ Asian ___ Native Pacific ___ American Indian ___ Hispanic ___

PUBLIC BENEFITS/INCOME (Optional)

(A financial needs test must be completed for many VR-purchased services.
The following income information will be helpful for your initial planning.)

Cash, Savings and Other Liquid Assets \$ _____

GROSS INCOME	Amount (Wk./Mo./Yr.)
Wages/Salary _____	\$ _____
Social Security Insurance (SSI) _____	\$ _____
Social Security Disability Insurance (SSDI) _____	\$ _____
Family Independence Program (FIP) _____	\$ _____
Temporary Disability Insurance (TDI) _____	\$ _____
Workers Compensation _____	\$ _____
Veterans Benefits _____	\$ _____
Unemployment Benefits _____	\$ _____
Private Disability Insurance _____	\$ _____
Pension or Annuity _____	\$ _____
Other Income _____ (Savings, including spousal income, rents, interest, etc.)	\$ _____

REHABILITATION EXPENSES (Non-Reimbursable)	WEEKLY AMT.
Medical _____	\$ _____
Rehabilitation/Adaptive Technology _____	\$ _____
Other Rehabilitation Needs _____	\$ _____

CERTIFICATION (Complete once you have met with a VR Representative)

I have been provided with an explanation of the VR program, my rights and responsibilities, and I have been given a Client Assistance Program (CAP) brochure. I have been informed that I can appeal decisions, and I have been told how to do this. I have also been advised of the necessity to have all services pre-approved by my ORS Representative and to keep him/her informed of any changes in my situation whether, medical, financial, or otherwise. I certify that the information I give is true and complete to the best of my knowledge and belief, and I know that false or misleading statements or failure to report changes may result in prosecution for intent to defraud. I understand that the information given is CONFIDENTIAL, and it will be used only for purposes directly connected with the administration of the VR program.

Signatures: _____
Applicant *Parent or Guardian (if applicable)* *Date*

Signature of Person who helped you complete application: _____ Phone: _____

Vocational Rehabilitation Counselor: _____